



Medical Marijuana Program



165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Modification, Remodeling, Expansion, Reduction or Other Physical, Non-Cosmetic Alteration of a Production Facility Form

INSTRUCTIONS: You must complete all portions of this application. This application must be accompanied by a check or money order in the amount of \$3,500.00, made payable to: "Treasurer, State of Connecticut." Upon approval, the applicant will be required to pay an additional \$1,500.00. All application fees are non-refundable.

Section A: Business Information

| | | |
|------------------------------------|-----------|--|
| 1. Legal Name of Applicant: | | |
| 2. Trade Name of Applicant: | | |
| 3. Applicant's Business Address | | |
| 4. City: | 5. State: | 6. Zip Code: |
| 7. Name of Primary Contact: | | 8. Primary Contact Title: |
| 9. Primary Contact E-mail Address: | | 10. Primary Contact Telephone Number: () - |

Section B: Production Facility Information

| | | |
|----------------------------------|---------------------------|---------------|
| 11. Production Facility Address: | 12. Producer License No.: | |
| 13. City: | 14. State: CT | 15. Zip Code: |
| 16. Telephone Number: () - | 17. Fax Number: () - | |

Section C: Changes to Production Facility

| | |
|---|-------------------------------|
| 18. Type of Change: <input type="checkbox"/> Modifications <input type="checkbox"/> Remodeling <input type="checkbox"/> Expansion <input type="checkbox"/> Reduction <input type="checkbox"/> Other: _____ | |
| 19. Proposed Start Date: | 20. Proposed Completion Date: |
| 21. Description of Project: _____ _____ _____ _____ | |



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22. Please provide the following information as part of your application:

- A blueprint, or floor plan drawn to scale, of the proposed area of the production facility.
- Copies of all licenses and/or permits required by the town necessary to complete work.
- List of all individuals who will be working at the site for the proposed time frame.
- Attach a detailed description of the security plan to be in place during this project to prevent against theft, diversion and/or loss.

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes. As the duly authorized representative of the applicant, I hereby make the above certifications on behalf of the applicant.

23. Signature:



24. Printed Name:

25. Date Signed:

I hereby certify that the above information is correct and complete.

26. Date Received:

- Approved
 Disapproved

Assigned Drug Control Agent Name:

Date of Action: